

# 2020 Application for Certification of Eligibility

## Oregon Volunteer\* EMS Provider Tax Credit

This form is electronic. If possible, please fill out as much on the computer as you can.

### Applicant

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(First, M.I., Last—please print legibly.) (Please print legibly—this is how we send confirmations.)

Social Security Number: \_\_\_\_\_ Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Mailing Address:

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### EMT Status

- Are you an Oregon certified Emergency Medical Services Provider?  Yes  No  
Please indicate your Oregon license:  EMR  EMT  AEMT  EMT-I  Paramedic
- How many hours during 2020 did you provide EMS Provider services in Oregon? (Include all stand-by, response, and training time.)  
Paid Hours: \_\_\_\_\_ Volunteer Hours: \_\_\_\_\_

\*A volunteer is a person properly trained under Oregon law who either operates an ambulance to and from the scene of an emergency or renders emergency medical treatment on a volunteer basis so long as the total reimbursement received for such volunteer services does not represent more than 25% of ones gross annual income, not to exceed \$3,000 per calendar year.

### Primary Station/Agency (Supervisor signature required below.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Secondary Station/Agency (If applicable.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Tertiary Station/Agency (If applicable.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

I attest that the information provided on this application is true and accurate:

\_\_\_\_\_  
Applicant Signature Date: \_\_\_\_\_

Primary Agency EMS Provider Supervisor Name (please print): \_\_\_\_\_

Primary Agency EMS Provider Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please either fax the completed form to (503) 494-4798, or mail to:  
Oregon Office of Rural Health | 3030 S Moody Ave | Ste 200 | Portland OR 97201  
Email is NOT ADVISED for this form.